

PSYCHOSOCIAL/BEHAVIORAL MEDICINE

FACTORS ASSOCIATED WITH STRESS IN HIGH SCHOOL STUDENTS. R. Avon, N. Batey, W. Birt, A. Chaudhry, E. Gladmon, A. Syed, P. Flanagan, C. Karkashian, and R. Gershon. Johns Hopkins University, School of Public Health, Baltimore, MD.

Stress in adolescents may be correlated with a number of maladaptive coping responses (i.e., drinking, drug use, sexual activity, etc.). Because these responses may result in adverse health outcomes, it is important to better understand stress and the determinants of stress in adolescents so that effective coping strategies can be developed.

In order to assess and characterize the relationship between perceived stress and quality of school life, a cross sectional study of high school students was recently conducted. Quality of school life was evaluated by measuring students' perception of safety and security at their school, incidents of sexual and physical harassment and violence, the environmental conditions at the school, opportunities to participate in sports and social events and level of social support from peers and teachers.

High school students from a large metropolitan high school were asked to complete an anonymous 11 page, 120 item questionnaire. The questionnaire contained items on stressors, coping mechanisms, perceived stress (distress), and health outcomes. Wherever possible, well defined and well characterized pre-existing scales were used.

A total of 971 completed, usable questionnaires were returned (98% response rate). Respondents had a mean age of 16 years, 52% were male, 78% were African-American, 60% were sexually active. The mean score on the stress scale was 36.4 (possible range 20-60). Stress was significantly correlated with several demographic and personal characteristics (male gender, sexual activity, academic programs) and school life variables (poor security, academic pressures, environmental conditions at school, and harassment).

These results indicate that potentially modifiable stressors may be significantly associated with perceived stress among high school students. Improvements in these areas may be beneficial to the overall health of adolescents.

ARE PATIENTS DIAGNOSED WITH ALCOHOL ABUSE IN PRIMARY CARE READY TO CHANGE THEIR BEHAVIOR? J Conigliaro, M McNeil, K Kraemer, R Conigliaro, M Joswiak, S Maisto. University of Pittsburgh, Pittsburgh, PA and Syracuse University, Syracuse NY.

The use of structured advice and individualized feedback about drinking known as a brief intervention (BI) is effective in reducing alcohol consumption and improving outcomes in hazardous drinkers (HAZARD). The success of BIs has been attributed to their ability to increase a patient's readiness to change addictive behaviors. Stage of change (SOC) describes a patient's readiness to change and is depicted by 5 stages: precontemplation or denial, contemplation or ambivalence, determination, action, and maintenance. Patients in the earlier stages are less likely to change behavior and therapy should focus on overcoming denial and ambivalence. Knowledge of a patient's SOC can be used to tailor a BI and increase its effectiveness. The purpose of our study was to determine the SOC of alcohol abusers and hazardous drinkers diagnosed in primary care settings.

Methods: We screened patients using the Alcohol Use Disorders Identification Test (AUDIT) and a measure of consumption at seven primary care sites. We used the SOCRATES-SA, a previously described instrument to assess SOC in alcohol abusers.

Results: 6635 patients were randomly screened. 741 (11.2%) screened positive for alcohol abuse (53% male, 21.8% non-white). 191 patients underwent a baseline assessment. Of these, 65 (mean age 43.4 yrs, 65% male, 29% non-white) met DIS criteria for alcohol abuse or dependence (DEP), while 126 (mean age = 44.6, 69% male, 24% non-white) were in the HAZARD group.

	Precontemplation	Contemplation	Determination	Action	Maintenance
HAZARD	85 (73%)	9 (8%)	7 (6%)	5 (4%)	11 (9%)
DEP	28 (45%)	10 (16%)	9 (15%)	11 (18%)	4 (7%)

Patients in the HAZARD group were more likely to be in the precontemplation or contemplation stage in regards to their drinking as compared to DEP patients ($p = 0.001$ for trend).

Conclusion: Patients in the primary care setting who screen positive for hazardous drinking are more likely to be in the precontemplation and contemplation stage. Treatment in this group should focus on overcoming denial and ambivalence. This offers the opportunity for the primary care physician to link a patient's medical condition to their drinking behavior as a means to enhance their motivation to change.

THE IMPORTANCE OF PHYSICIAN ENTHUSIASM FOR CANCER SCREENING ADHERENCE. SA Fox, N Duan, C Paul. Division of General Internal Medicine, University of California, Los Angeles, and RAND, Santa Monica.

Predictors of cancer screening adherence are usually immutable patient characteristics such as SES (socioeconomic status), i.e., education or income, and therefore difficult to alter in interventions. This study was conducted to identify the baseline predictors of breast cancer screening adherence among 1517 mostly low-income older women who are participating in a Los Angeles church-based trial designed to increase screening behaviors. A 45 minute bilingual telephone survey was conducted of 43% white, 31% black, and 22% Hispanic women; the rest was mixed race. The average age was 63 years.

Approximately 40% of the sample was non-adherent with regular mammography screening (2 in the previous 4 years). Women's perceptions of their physicians' enthusiasm for mammography was the strongest and most constant predictor for three outcomes: compliance with mammography, ever had mammography, and clinical breast exam in past two years. After controlling for SES and other factors using multiple logistic regression, women whose physicians had some or a lot of enthusiasm for mammography were over 2 1/2 times more likely (Odds Ratio [OR] = 2.6) to have been adherent compared to women whose physicians had little or no enthusiasm.

Because of the strong policy relevance of better understanding this key communication predictor of adherence, a focus group was conducted after the survey to operationalize women's perceptions of doctor enthusiasm. A broader concept of doctor caring emerged which is feasible for primary care physicians to learn and which has great potential to increase screening among previously non-adherent women.

DEVELOPMENT OF A DISEASE-SPECIFIC MEASURE OF DIABETIC PATIENTS' DESIRES TO PARTICIPATE IN MEDICAL DECISION MAKING. CE Golin, MR DiMatteo, N Duan, B Leake, J Heritage, L Gelberg, UCLA, Los Angeles, CA and RAND, Santa Monica, CA.

Researchers postulate that increasing diabetic patients' participation in medical decision making will improve their adherence to self-care. However, little is known about diabetic patients' desires to participate in decision making. Based on extensive literature review, we designed a scale to measure the importance placed by diabetic patients' on aspects of participation in medical decision making. After pilot-testing and revision, the final scale contained 11 items. We then conducted two studies to assess its reliability and validity and in the second study used multivariate linear regression to assess factors predicting a desire to participate in medical decision making.

We first conducted a telephone survey of 69 patients with type II diabetes registered at a general medicine clinic in Los Angeles; 64 (93%) participated. Cronbach Coefficient Alpha for internal consistency reliability was .90. Pearson Correlation Coefficient was .71 for Test-Retest reliability. Our scale correlated inversely with age ($p = .07$) and positively with attendance of diabetes classes ($p = .04$). To assess the extent to which our scale overlapped with normative values for patient autonomy, we compared it with the Autonomy Preference Index (API) and found no statistically significant correlation.

Second, we interviewed face-to-face 240 diabetic patients at an inner city general medicine clinic; 229 (95%) participated. Cronbach Coefficient Alpha was .87. Factor analyses revealed one factor. Patients' desires to participate correlated with visit satisfaction ($p = .0002$) and perceptions that the doctor facilitated participation ($p = .0003$). After controlling for demographics, health status, attendance of diabetes educator visits, and prior experience with care: African American ethnicity ($p = .0008$); visiting a diabetes educator ($p = .04$); age ($p = .004$); and prior negative experiences with interpersonal aspects of care ($p < .0001$) predicted patient desires to participate actively.

In conclusion, we developed and validated a disease-specific scale to assess diabetic patients' desires to participate in making medical decisions. Diabetic patients who are middle aged, African American, attend diabetes education classes or who have had poor interpersonal experiences with prior care desire more participation in decision making.

DOES FACILITATION OF PATIENT PARTICIPATION IN MEDICAL DECISION MAKING AFFECT DIABETIC PATIENTS' SATISFACTION WITH CARE? CE Golin, MR DiMatteo, N Duan, B Leake, L Gelberg, UCLA, Los Angeles, CA and RAND, Santa Monica, CA.

Researchers increasingly advocate patient participation in medical decision making. Because most diabetic care is self-administered, treatment requires active patient participation. Few studies have examined the impact of patient participation in medical decision making on patient satisfaction. We examined how type II diabetic patients felt about their medical decision-making role and used multivariate regression analysis to examine the impact of this role on patient satisfaction. We sampled and interviewed 240 diabetic patients at a teaching hospital's general medical clinic (96% response rate). We developed a reliable ($\alpha = .87$) disease-specific, 11-item scale to assess patients' desires for participation in medical decision making. A sample item is "How important is it to you for your doctor to give you all the information you need to care for your diabetes?" We used a previously validated 9-item scale to measure patients' perceptions of their doctor's facilitation of their participation in decision making. A sample item is "My doctor explains all the treatment options to me so that I can make an informed choice." After standardizing the two scales, we calculated, for each patient, a discrepancy score of the difference between the desire to participate and the perception that their doctor had facilitated participation. Patient satisfaction was measured using a previously validated instrument.

Patients were relatively dissatisfied (mean=70; range=30-91). Patients perceived a high degree of physician facilitation of participation (mean=48; range=29-54). After controlling for demographics, health status, duration of relationship with doctor, waiting time, prior satisfaction, and desires to participate, the discrepancy between patients' desires and their perception of the doctors' facilitation of participation predicted patients' visit satisfaction ($p < .0001$). A change in discrepancy score from 25th to 75th percentile resulted in a 9 point increase in satisfaction. In other groups, an 18 point decrease in satisfaction has been associated with a 25% increase in intent to change providers. For our patients, the discrepancy between desires for and facilitation of participation had an important effect on patient satisfaction. Because patient satisfaction with care has been shown to influence adherence to treatment regimens, greater participation in medical decision making may stimulate patients to take better care of their diabetes.

TIME IS NOT THE ESSENCE: THE RELATIONSHIP BETWEEN VISIT LENGTH, PHYSICIAN INTERPERSONAL SKILL, AND PATIENT SATISFACTION. CT Grimm, M Wang, M Lee. VA Medical Center, Sepulveda CA, and UCLA.

Patient satisfaction with ambulatory care visits is associated with the physician listening to all concerns, answering all questions, and not acting hurried. However, as the pressure to see more patients mounts, physicians feel that they are hurried, and that they do not have time to devote to the personal aspects of the patient-physician relationship. This study investigates the relationship between visit length, physician interpersonal skill, and patient satisfaction.

As part of a larger study of physician communication, 32 internal medicine interns were videotaped seeing patients in a VA ambulatory care clinic 3 times over a year (T_0 to T_3). After each visit patients filled out the ABIM Patient Satisfaction Questionnaire (PSQ). 2 coders rated each tape using a 24-item Interpersonal Communication Skills Checklist (ICSI), and all tapes rated by coder pairs whose scores correlated at a .001 significance level by Spearman rank correlation were included.

211 visits were taped, and 174 scored by coder pairs with good inter-rater agreement were studied. By factor analysis the PSQ items grouped into a questioning and an education scale. The ICSI items were grouped into 5 scales. In the beginning of the year interns spent 20.8 ± 7.7 min. with patients, and 8.5 ± 4.4 min. presenting to attendings. By the end of the year, interns spent 17.3 ± 7.8 min. with patients, and 7 ± 4.5 min. presenting. Patient satisfaction was high on both scales at all time points (4.17 to 4.70 on a 5-point, Likert-type scale), and was not related to visit length. Physician interpersonal skills were also not related to visit length. Patient satisfaction with physician education, however, correlated with some interpersonal skills.

ICSI Category:	T ₀	T ₂	T ₃
Information Giving	.32	.05	*.65
Closure	*.43	.28	*.60

* $p < .02$, $p < .08$

Patient satisfaction is more related to the quality than to the length of the patient-physician interaction. Although the visits studied were relatively long, these results indicate that physicians can use appropriate interpersonal skills, and leave their patients feeling that their concerns have been met and their questions answered, in shorter as well as longer office visits.

THE "DIFFICULT" PATIENT, CLINICAL PREDICTORS AND CORRELATES WITH OUTCOME. Jeffrey L Jackson, Madigan Army Medical Center, Tacoma WA. Kurt Kroenke, Uniformed Services University of the Health Sciences, Bethesda, MD

Patients are sometimes considered difficult by physicians, a topic rarely discussed openly. Our purpose was to identify predictors of clinician-perceived difficulty among patients presenting with physical complaints and explore correlates with clinical outcomes. 500 patients presenting to a general medicine clinic with a chief complaint of a physical symptom completed a survey on symptom characteristics, expectations, functional status and were interviewed with the PRIME-MD to diagnose DSM-IV depressive and anxiety disorders. Clinicians completed the Difficult-Doctor Patient Relationship Questionnaire postvisit. Outcomes, including cost, satisfaction, unmet expectations, functional status and symptom resolution were assessed immediately postvisit, at 2 weeks and 3 months. **Results:** Patients had a mean age of 55 years, half were women, 49% were white, 45% Afro-American and 6% other. Independent predictors of difficulty included: mood or anxiety disorder (OR: 2.9, 95%CI: 1.5-5.4), serious illness worry (OR 2.1, 95%CI: 1.1-3.9), ≥ 5 symptoms on a 15-symptom checklist (OR: 1.9, 95%CI: 1.1-3.4) and stress in the past week (OR: 1.8, 95%CI: 1.0-3.3). There was a dose-response relationship between the number of predictors present and the likelihood being considered difficult. Patients were categorized as difficult 3%, 14%, 21% and 32% of the time when 0, 1-2, 3 or 4 predictors were present, respectively. Difficulty was not independently associated with age, race, sex, functional status or with the type, severity or duration of presenting complaint. "Difficult" patients were more likely to have unmet expectations postvisit ($p = 0.005$) and at two weeks ($p = 0.009$), were less likely to be fully satisfied with the care they received both immediately postvisit ($p = 0.003$) and at two weeks ($p = 0.01$), and had more frequent visits with clinicians in the subsequent three months (7.3 vs 4.7, $p = 0.00001$). Clinicians spent nearly twice as much ($p = 0.0001$) on prescriptions for patients considered difficult but were not more likely to refer such patients to subspecialists or spend more on diagnostic testing. There was no difference in symptom resolution at 2 weeks or 3 months.

Conclusion: Clinical factors which increased the likelihood of being considered difficult included the presence of a mood or anxiety disorder, patient serious illness worry, stress or more than 5 concomitant symptoms. "Difficult" patients were less likely to be satisfied with the care they received, more likely to have postvisit unmet expectations, had higher health utilization and higher prescription costs.

MENTAL DISORDERS IN PATIENTS PRESENTING WITH PHYSICAL COMPLAINTS: CLINICAL PREDICTORS AND OUTCOMES.

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Mental disorders are common in patients presenting with physical complaints to primary care physicians and are frequently not recognized. Our purpose was to identify clinical predictors of depressive and anxiety disorders among patients presenting with physical complaints and to assess the impact on outcomes. 500 patients presenting to a general medicine clinic with a chief complaint of a physical symptom were interviewed with PRIME-MD to diagnose DSM-IV depressive and anxiety disorders. Clinical predictors were analyzed using logistic regression. Outcomes, including symptom improvement, functional status, unmet expectations, patient satisfaction, clinician-perceived patient difficulty, health utilization and costs, were assessed immediately postvisit, at 2 weeks and 3 months. **Results:** Patients had a mean age of 55 years, half were women, 49% were white, 45% African-American and 6% other. A depressive or anxiety disorder was present in 146 (29%) of patients. Independent clinical predictors of Anxiety or Depression included stress in the past week (OR: 4.9 95% CI: 3.0-8.0), >5 symptoms on a 15-symptom checklist (OR: 3.1 95% CI: 1.9-5.2), self-rated health only poor or fair (OR: 2.7 95% CI: 1.4-5.0), clinician perception of the patient as difficult (OR: 2.4 95% CI: 1.3-4.4), symptom severity >6 on 10 pt scale (OR: 2.0 95% CI: 1.2-3.3) and age <50 (OR: 1.6 95% CI: 1.0-2.7). There was a dose-response relationship between the number of "predictors" present and the likelihood of having a disorder. A mental disorder was present in 8%, 16%, 43%, 69% and 94% of patients with 0, 1, 2, 3 or 4 predictors respectively. Patients with mental disorders were more likely to have unmet expectations postvisit ($p=0.001$), be considered difficult ($p<0.0001$) and report persistent psychiatric symptoms and stress even 3 months after the initial visit. Psychiatric status was not associated with a particular type of presenting symptom, with symptomatic improvement, health utilization or visit costs.

Conclusion: Screening all primary care patients for mental disorders has not been shown to be either cost-effective or feasible. Simple clinical clues in patients presenting with physical complaints identifies a subgroup who may warrant further evaluation for depressive or anxiety disorder. Such disorders are associated with unmet patient expectations, increased provider frustration and persistent psychiatric symptoms and stress.

THE PATIENT'S PERSPECTIVE ON PHYSICIAN COUNSELING FOR EXERCISE.

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Study Objective: This study explored patient reactions to physician counseling for exercise to better understand the impact such counseling has on patients.

Methods: Design--A qualitative study using semi-structured in-depth interviewing. Setting--Intervention and control groups from a randomized controlled trial of Physician-based Assessment and Counseling for Exercise (PACE) at a large HMO. Subjects--A total of twenty-nine subjects were selected from both groups by their self reported exercise behavior with the following criteria: 1) exercising less than three times per week at baseline and 2) no change or increased exercise at six month follow-up. Twenty subjects saw physicians who received training on exercise counseling (intervention group [I]) and nine saw physicians who did not receive training (control group [C]).

Results: Twenty-one patients (17/20 I; 4/9 C) received counseling and had a neutral/positive reaction and two patients (1 I; 1 C) who did not receive counseling expressed a desire for it. Patients who liked the counseling described their physicians as "encouraging," "supportive," or "caring." Thirteen (10/17 I; 3/4 C) of the counseled patients did not alter their exercise behavior following their physician's intervention despite positive reactions. Two (both I) of these subjects stated that although they appreciated the counseling about the need and reasons to exercise, this did not help them overcome the "difficulties" of starting a program. Another (I) of these subjects described a specific strategy that their physician used, unsuccessfully, to help him adopt an exercise program. Eight (7/17 I; 1/4 C) subjects started exercise programs. Five (4 I; 1 C) of those eight either felt "spurred" to start a program that they had been planning to start or increased their physical activity "sporadically." The three others (all I) described how their physicians either elicited a "commitment" (2) or "needed" (1) them through repeated messages to start exercising.

Conclusions: Patients accept, often appreciate, and sometimes expect physician counseling for exercise that is supportive and expresses caring. However, such approaches to counseling may only induce behavior change when the change is imminent or when accompanied by other strategies such as eliciting commitment or frequently repeating messages.

IS IGNORANCE SOMETIMES BLISS? A HISTORICAL PERSPECTIVE ON THE LIMITATIONS OF EARLY CANCER DETECTION.

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Recent controversial articles have argued that early intervention may have little impact on the outcome of many breast and prostate cancers. Such claims are not new. For 50 years, doctors have noted the limitations of early cancer detection and therapy. By reviewing medical articles on cancer screening since 1945, this paper examines the enduring dogma of early detection and reveals its complexities.

With the end of World War II, Americans faced a new "formidable enemy," cancer. Using vivid military images, lay and medical groups promoted aggressive early cancer detection followed by surgical "attack." Recommended screening included routine breast and rectal exams as well as microscopic study of seemingly benign prostate and breast tissue specimens. Yet in contrast to the military setting, in which early detection of the enemy was always desirable, searches for early and ostensibly curable tumors often generated problematic data. Autopsies, for example, revealed that many small cancers never caused problems in life, while biopsies often showed in-situ lesions of unclear prognosis. Critics argued that cancer mortality was biologically predetermined, and thus not alterable via screening and medical therapy. Although some physicians advised a "watch and wait" policy for "latent" cancers, the ethos of early detection and radical treatment promoted the use of highly aggressive therapies, including disfiguring operations and surgical castration.

As testing for PSA, BRCA1, BRCA2 and other serum and genetic cancer markers increasingly enters medical practice, two key facts should be recalled: 1) cancer screening technologies have long generated data that are ambiguous and difficult to apply clinically; and 2) despite these often uncertain results, the persistent "all or nothing" ethos of the war on cancer has at times oversold the value of early detection and aggressive therapy. The historical record reveals that scientific evaluation alone is unlikely to resolve the complex clinical issues raised by new cancer screening technologies.

DO PATIENT PREFERENCES FOR AUTONOMY IN ROUTINE HEALTH CARE PREDICT DESIRE FOR FAMILY AND PHYSICIAN INPUT IN SERIOUS ILLNESS DECISIONS?

DL Mansell, L Kazis, C Duefield, R Poses, T Heeren

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Background: Most studies of patients' (PTs') preferences for decision-making in serious illness have focused on their relationship to the doctor (MD), not on family (FM) involvement. Little is known about whether a PT's desire for autonomy in decisions (DEC) about routine health care predicts the PT's desire for FM and MD involvement in DEC about serious illness.

Method: Cross-sectional survey of VA outpatients; 255 of 591 PTs completed the survey. We asked PTs a global question about the proportion of the input (in %) that they wanted from themselves, their FM, and MD in decisions about serious illness (to total 100%). PTs also completed the Autonomy Preference Index (API), which measures desire for autonomy in routine health care decisions (AUT) and desire for information about health (INF); scores range from 0 to 100.

Results: PTs had a mean age of 63.2 and 4.0+/- 2.0 chronic illnesses. 95% were male, 62% were married, 55% had a high school education or less, 99% were white. On average, PTs wanted 39% of the input for DEC made by MD, 18% by their FM, and 43% by themselves. For the API, mean score for AUT was 51, and mean score for INF was 81.7. The correlation between PT input and MD input was -0.84, so only Pearson product correlations of PT input and FM input with the API scales were examined. AUT's correlation with PT input was 0.46 ($p=0.0001$); INF's correlation with PT input was 0.30 ($p=0.0001$). AUT's correlation with FM input was 0.05 ($p=0.46$), and INF's correlation with FM input was -0.12 ($p=0.07$).

Conclusions: PTs who desire autonomy in routine health care desire more input into decisions about serious illness. Also, PTs who desire more information about health desire more input into serious illness decisions. PTs' desire for FM input about serious illness is less than their desire for MD input. Desire for autonomy in routine health care does not predict desire for FM input; desire for more information only weakly predicts desire for less FM input.

THE ROLES OF THE FAMILY AND PHYSICIAN IN PATIENT DECISION-MAKING ABOUT SERIOUS ILLNESS.

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Background: Most studies about patient (PT) decision-making focus on the doctor (MD) and PT. However, many PTs also involve their family (FM) in decision-making. We examined the role of demographic characteristics, illness severity, quality of life, and prior serious illness experience on the PT's desire to have FM and MD involvement in decision-making about serious illness.

Method: Cross-sectional survey of VA outpatients; 255 of 591 completed the survey. Demographics and prior serious illness experience were measured by self report, quality of life with the SF-36, and severity via chart abstracts. We asked PTs a global question about the proportion of the input (in %) that they wanted from themselves, their FM, and MD in decisions about serious illness (to total 100%). Backward elimination procedures were performed to determine the models of best fit. The % input from FM and PT were chosen as dependent variables because the correlation between desire for input from PT and input from MD was -0.84. P values are two-tailed.

Results: The PTs had a mean age of 63.2 and 4.0+/- 2.0 chronic illnesses; 95% were male, 62% were married, 55% had a high school education or less, 99% were white. On average, PTs wanted 39% of the input for decisions made by their MD, 18% by their FM, and 43% by themselves. Females ($p=0.092$), married PTs ($p=0.0001$), PTs with prior serious illness in a FM member ($p=0.046$), and PTs with role limitations due to emotional problems ($p=0.042$) wanted more FM involvement; $R^2=0.097$. Younger PTs ($p=0.0001$) wanted to be more involved in decision-making for themselves; $R^2=0.077$.

Conclusions: PTs wanted to share decision-making with their MDs about serious illness but wanted less FM involvement. Demographic characteristics, severity of illness, prior serious illness experience, and quality of life predict only some of the desire for input from MD and FM for decisions about serious illness.

IDENTIFIED PHYSICIAN-PATIENT AGENDA DISCORDANCE IS NOT RELATED TO PATIENT OR PHYSICIAN VISIT SATISFACTION.

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Patients and physicians may have differing agendas for outpatient visits. We hypothesized that discordant agendas would adversely influence visit satisfaction for patients and physicians.

A total of 339 outpatient general medicine visits were examined by surveying both physician and patient after a visit on their respective agendas for the visit and on a 5 item satisfaction scale. Complete data was available for 281 visits. Discordant visits, defined as those in which at least 1 of the 2 primary agenda items for the patient or physician did not appear on the other's list, comprised 23% of visits. Mean visit satisfaction for patients was 4.69 (5 point Likert scale, 5= excellent) for discordant visits when a patient's agenda was not listed by the physician, 4.67 for discordant visits when a physician's agenda was not listed by the patient, and 4.64 for all other visits. These differences were not significant. Mean physician visit satisfaction was 4.12 when a patient's agenda was not listed by the physician, 4.08 when the physician's agenda was not listed by the patient, and 4.08 otherwise, also insignificant differences. For all 281 complete visits patient satisfaction of 4.65 was greater than the physician satisfaction of 4.09 by chi-square at a .01 level. The only variable affecting satisfaction was physician identification of a patient as difficult, associated with reduced physician satisfaction of 3.70.

Agenda discordance was unrelated to visit satisfaction. This could be due to physicians and patients recognizing and dealing with each other's agendas but not prioritizing them, or to our possible over-estimation of discordance by open-ended agenda listing. True unrecognized agenda discordance may be rare in practice.

TWO PRIMARY CARE CULTURES FROM DEFINING QUALITY OF CARE AND DESCRIBING MOST DIFFICULT PATIENTS. *AE Miller, J Westly, JC Peirce, WH Billica, EH Gruner, JA MacKenzie, LK O'Malley.* Good Samaritan Regional Medical Center, Phoenix, AZ

The purpose of the study was to describe the assumptions (below the level of awareness) that formed the basis for the professional cultures of physicians who found somatizing patients difficult to manage versus those who found them a challenge for a needs analysis for developing a curriculum for primary care physicians in the management of somatizing patients. Increasingly these are being requested by managed care plans for use in the education of their primary care physicians.

A structured interview was developed by an interdisciplinary team of 2 general internists, 3 clinical psychologists, a psychiatrist, and a family physician interested in the above curriculum. This was administered to 5 private family physicians and 4 private general internists in individual interviews; to a group of 9 internal medicine residents and one faculty in another part of Phoenix; and through participant observation of residents, faculty and practicing physicians in an internal medicine residents clinic, a family practice residents clinic, and comprehensive health center, each over a period of several months. Two key prompts were: (1) how do you define quality of care?, and (2) describe your most difficult, demanding and/or unsatisfied patients; five supplemental questions were used for elaboration.

The dominant culture felt hopeless because they were dealing with non-medical problems for which they had no training and felt overwhelmed by the enormity of the problem and the complexity of the context. Quality of care came from the procedural expertise of the physician, medical journals and scientific research that are "the source of all truth," and those who have more education and expertise who possess wisdom and truth. These physicians felt the need to stay in control as expressed by: "patients are incapable of helping themselves," "the patient's life is in my hands," "physicians know the patient's need without patient feedback," and "physicians must stay objective and personally removed throughout the life-cycle of the relationship with the patient."

The recessive or shadow culture was future oriented desiring "mergers" of the various disciplines within internal medicine, having a balance between patient care, teaching and "Medicare outcomes consulting," with frequent mention of a population perspective. Quality of care was related to the degree of responsibility patients took for their lives, and this was better accomplished through working in an interdisciplinary team, being helpful, compassionate and "priestly in guiding such patients through adversity."

Any curriculum for a large primary care group will encounter both cultures. These differences will have to be brought into awareness and negotiated if cultural change will ensue.

A RANDOMIZED CLINICAL TRIAL OF A GROUP EMPOWERMENT PROGRAM FOR SOMATIZING PATIENTS; SIX MONTHS FOLLOW-UP RESULTS. *IC Peirce, AF Miller, LS Mayer, J Westly.* Good Samaritan Regional Medical Center, Phoenix, Arizona

The purpose of this study is to determine whether a group empowerment program would improve the health status of patients with somatizing problems (the propensity to experience and report somatic symptoms that have no pathophysiologic explanation, to misattribute them to disease, and seek medical attention for them) as measured by the SF-36 while decreasing office visits and laboratory tests.

Inclusion criteria included patients with 10 or more visits the year prior to the study, had symptoms unexplained by disease that were vexing to both the patient and physician, and could participate in group activities for up to two years. Patients were recruited from a family practice residents' clinic, and internal medicine residents' clinic and a comprehensive health center, and were randomly allocated to the intervention or control group. The group empowerment program consisted of 12 two-hour sessions over 6 weeks followed by weekly maintenance sessions designed to provide mutual support for skills to increase a person's energy and sense of capability. The control group was followed by regular telephone calls with monetary payment for completion of each of the health status surveys. Of 93 people 46 were allocated to the intervention program. The mean age of each group was 52 years with 77% females in the control and 85% (NS) in the intervention groups. As reported previously, patients showed depression of age-adjusted scores in all of the 8 domains of the SF-36 at baseline.

Using analysis of covariance to control for the baseline, clinically significant changes with mean changes varying from 8 to 20 SF units, were seen in all scales at 6 months compared to the baseline in the intervention group. There were corresponding increases in the control group for bodily pain and role emotional making the differences between the control and the experimental statistically insignificant in these two domains. In 5 of the remaining domains, no change existed in the controls. In physical function the control group showed a statistically significant reduction of 5 units. Using analysis of covariance to control for six weeks scores, there was no change between six weeks and six months indicating that all of the effect was maintained through six months.

Office visits decreased from 5.4 visits per 6 months at baseline to 3.7 in the intervention group with no change in the control group. There was a mild negative correlation of -0.20 between the office visits and physical function suggesting that factors other than improved physical function contributed to the decreased office visits.

COPD PATIENTS' CONCERNS AND EXPECTATIONS REGARDING LIFE-SUSTAINING TREATMENTS NEAR THE END OF LIFE. *MP Pfeiffer, CK Mitchell, LC Collins.* Division of General Internal Medicine, University of Louisville, Louisville, KY.

Chronic obstructive pulmonary disease (COPD) is a common and progressive chronic illness with the prospect of intense and aggressive medical care near the end of life (EOL). To assess the concerns, expectations, and beliefs of COPD patients regarding EOL care and physicians' roles, we completed structured interviews with 100 consecutive eligible ambulatory patients with a clinical diagnosis of COPD undergoing pulmonary function testing.

Thirty-one patients probably or definitely did not want life-sustaining treatments (defined to possibly include CPR) in their current state of health. While 13 patients specifically did not want mechanical ventilation if required to return to their current state of health, only one of these had ever been on a ventilator before. Of 22 patients previously on mechanical ventilation, 15 wanted unlimited time again and 6 wanted limited time (1-100 days) of ventilation if required.

Of the 100 patients, 81 thought the quality of the life they had left was more important than the quantity of life. Neither disease severity, as judged by FEV1.0 percent predicted ($p=0.84$) or prior ventilation ($p=0.47$), nor demographic variables including age, gender, race, education, and income (all p -values > 0.50) affected the decision regarding choosing quality versus quantity of life.

Patients ranked five informational issues regarding life-sustaining treatments from most to least important as follows: the eventual chance of survival, the expected quality of life after treatment, a description of the treatment, associated pain and suffering, and cost.

In evaluating adverse events associated with end of life care, 61% of patients were most concerned with emotional suffering by their families, 22% their own pain and suffering, 11% death itself, and 5% cost.

Patients were equally split on the physician's biggest role in EOL care with 38% believing it is to cure illness or prolong their life, 35% believing it is to guide and counsel, and 27% believing it is to minimize pain and suffering. These beliefs were not affected by measures of disease severity (all p -values > 0.50).

COPD patients' concerns and expectations about EOL care are not intuitive. Prior mechanical ventilation is associated with a willingness to have this treatment again. Most patients want a focus on quality of life but are not readily identified by objective variables. Physicians should focus discussions regarding end of life care on the chances of survival and the expected quality of life after treatment and be aware of patient concern about the emotional impact their treatment might have on their families.

PATIENT AND PRIMARY CARE PHYSICIAN ATTITUDES TOWARD MENTAL HEALTH CONCERNS. *DR Reifler, D Kan, D Gaziano.* Northwestern University Med. School, Chicago, IL

Purpose: Mental health concerns (MHCs) such as depression, anxiety, and substance abuse are common in primary care patients and are often inadequately addressed in visits to primary care physicians. This study assesses patient and physician attitudes toward discussing such concerns in an internal medicine clinic. **Methods:** We surveyed 278 patients and 87 physicians in a large academic internal medicine clinic. Patients were asked to participate in the waiting area; 258 (92.8%) responded. Surveys included quantitative questions with Likert scales of 1 (very little) to 5 (very much) and open-ended qualitative questions. Physicians were given similar written surveys; 80 (92.0%) responded. **Results:** Patients were 59% women, 61% white, 55% unmarried, and 61% college-educated, with a mean \pm SD age of 37.7 \pm 12.7 yrs. Patients thought discussion of MHCs with their internists was important (mean \pm SD Likert scale score, 3.6 \pm 1.2); they wanted more time allocated to these issues (2.7 \pm 0.9) than they had had in the past (2.0 \pm 1.1; $p<0.01$). Patients tended to think MHCs were more important if they were over 35 years old ($p<0.01$) or had had previous psychiatric treatment ($p<0.01$). Qualitative responses generally favored the discussion of MHCs: "Without a whole picture of a patient, you cannot heal the patient totally." A minority of patients thought MHCs were outside the realm of internists: "Why would you talk to an air conditioning repairman about your TV set?" Physicians were 64% residents, 63% men, 64% white, 32% Asian, and 29.9 \pm 4.4 yrs old. Physicians thought discussion of MHCs with patients was very important (4.1 \pm 0.8); they wanted to allocate more time (3.1 \pm 0.8) than they had allocated in the past (2.8 \pm 0.8, $p<0.02$) to these issues. Attending physicians reported they spend more time on MHCs than residents reported (3.1 \pm 1.0 vs. 2.6 \pm 0.6, $p<0.01$). In qualitative responses, physicians most often listed satisfaction in treating the whole patient, improved patient rapport, and elimination of wasted effort as factors they liked about addressing these issues: "A little bit of listening and reflection goes a long way." Physicians overwhelmingly listed time limits as their biggest dislike about addressing these issues, followed by emotional drain, patients' resistance, and lack of training in diagnosis and management: "It's frustrating, I often feel there is not much we can do." **Conclusion:** Both patients and physicians recognized the importance of addressing mental health concerns in a primary care visit. Facilitating efforts should aim to train internists in management strategies that are efficient with time and emotional burden and to educate patients to accept a broad role for their primary care physicians.

WEIGHING THE EVIDENCE: SOURCES OF INFORMATION UTILIZED BY PATIENTS PRIOR TO PROSTATE CANCER TREATMENT DECISIONS. *MM Schapira.*

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A survey was conducted to identify the sources of information utilized by patients with localized prostate cancer when making treatment decisions. Subjects were recruited from 4 hospitals (2 Veterans Administration Hospitals and 2 private hospitals) in Wisconsin as part of an ongoing study of decision making for patients with localized prostate cancer. Subjects were surveyed three months after the initiation of treatment regarding sources of information utilized and relative importance of each source in making a treatment decision.

The study cohort included 79 subjects. The mean age was 70 years. Ninety-one percent were Caucasian, 8% were African-American, and 1% Hispanic. Thirty-nine percent were treated with radical prostatectomy, 33% with radiation therapy, and 28% with watchful waiting. All subjects had consulted a urologist prior to treatment, 43% had consulted a radiation oncologist, 38% had consulted a general medical doctor, and 7% had consulted a medical oncologist. Seventy-six percent had utilized written pamphlets or materials and 15% had read medical journals. Thirty-four percent obtained information from the newspaper, 35% from magazines, and 29% from books. Forty percent obtained information from a friend with prostate cancer. Subjects utilized a mean of 6.2 sources of information (SD 3.5) prior to treatment decisions. When asked to rank the helpfulness of each source utilized on a scale of 1 (not helpful) to 5 (extremely helpful), the following assessments were made (mean, SD): radiation oncologist (4.3, 0.7), urologist (3.9, 1.0), general medical doctor (3.7, 1.2), and medical oncologist (3.5, 1.3). Other sources that ranked highly included written pamphlets or materials (3.7, 1.0), books (4.0, 1.1), and friends with prostate cancer (3.4, 0.9). In conclusion, patients consult a variety of medical professionals, media sources, educational materials, and personal contacts when considering treatment options for prostate cancer.

IMPROVEMENT OF THE PHYSICIAN'S PERCEPTION OF THE PATIENT'S DISEASE-RELATED EXPERIENCES. *F Stiefel, M Vannotti, R Moeri, P Guex.* Medical Outpatient Clinic, Division of Psychosocial Medicine; University of Lausanne, Switzerland

Study design: Joint survey among patients and their physicians. **Background:** While the importance of physical and emotional impact of chronic disease and coping strategies of the patients has been recognised and their effects on symptom behaviour and medical care utilisation has been demonstrated, little attention has focused on the physicians' capacities to perceive these disease-related experiences of their patients. **Objective:** To assess and improve correlations between patients' disease-related experiences and the perception of these variables by their physicians. **Methods:** A 15-item questionnaire (designed after the medical literature) with a Likert-Scale assessing the physical and emotional impact of chronic disease on the patient and his ability to cope with a complex biopsychosocial situation (chronic disabling low back pain). A second questionnaire assessing the perception of the physicians of the physical and emotional impact of chronic disease on their patients and their ability to cope has been distributed among the physicians in charge to evaluate the disability claims of these patients. **Population:** 150 patients and 10 physicians accepted to participate to the study. **Results:** a) high correlations between physicians and patients have been found in regard to the physical impact of the disease and a lower correlations in regard to the emotional impact and coping b) correlations increased over the course of the study.

Conclusions: Results of this pilot-study indicate that (1) this simple questionnaire seems to be a valuable tool to assess the needs in regard to the training of psychosocial issues in the medical setting, and that (2) it improves the physicians' skills to perceive their patients' subjective disease-related experiences.

TEACHING CROSS-CULTURAL AWARENESS IN HEALTH CARE: INSIGHTS ABOUT PROGRAM DESIGN, CONTENT, AND FACILITATION. A Monroe-Fowler and KM Taylor. St. Joseph Mercy Hospital, Ann Arbor, Michigan.

Efforts to increase staff awareness of the impact of cross-cultural dynamics on health care delivery prompted development of a sixteen hour workshop for general internal medicine faculty and house officers, mid-level providers, care managers, and office staff on components of cross-cultural sensitivity and competence. Participant feedback indicates that the workshop succeeded in (1) increasing awareness of the complexities, benefits, and challenges of a culturally pluralistic society (2) increasing awareness of the attitudes and skills needed to effectively work across cultural differences and (3) increasing staff enthusiasm for continued multicultural issues in health care. Further analysis of participant feedback also suggests that effective teaching about cross-cultural sensitivity and competence includes using a combination of active and passive learning activities; providing opportunities to explore diversity issues on both a personal and theoretical level; and structuring ongoing forums to discuss current diversity issues in the workplace and practice problem solving.

EFFECT OF A PERSONAL HEALTH ORGANIZER ON DOCTOR-PATIENT COMMUNICATION.

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In spite of previous research that has shown portable medical records to be helpful, the use of portable medical records has not been widespread. This study assesses the effect of a personal health organizer, a portable medical record that promotes interaction between the health care provider and the patient, on the health care perceived by the patients.

This study was a six-month prospective observational study involving patients from the Durham VA Medical Center outpatient general medical clinics. Ten health care providers were given an introduction to the personal health organizer (which is formatted like a medical record) and then were asked to refer patients to the study. The patients were asked to attend 3 focus groups over the following 6 month period to discuss how to use the organizers. At each of the focus group meetings, the patients completed questionnaires regarding the usefulness of the organizers and if the use of the organizers affected their medical care.

Forty-two patients were referred and enrolled into the study. The average age of participants was 57 years old (range 31-82); 98% were male; 75% were white, 25% were African-American. 22 of 42 patients (52%) returned to at least one of the focus groups. Of the 22 subjects responding, 91% of subjects agreed that the portable health organizer made them feel more in control of their health. 91% of subjects agreed that the organizers helped them to understand their medical problems. 68% of subjects agreed that the organizer helped them to talk to their health care provider. 68% agreed that the organizer helped them to receive better health care. 82% of subjects stated that they would continue to use the organizer when the study was over.

The personal health organizer was found to improve doctor-patient communication, and to improve patient's feeling of control over their medical problems.

PHYSICIAN-PATIENT COMMUNICATION ABOUT NONCONVENTIONAL THERAPY (NCT) USE IN HIV CARE: RESULTS OF A PHYSICIAN (MD) SURVEY. MK Wynia, IB Wilson. New England Medical Center Boston, MA.

In national surveys 1/3 of Americans report NCT use annually at an estimated cost of \$13.7 billion, of which 3/4 is out of pocket. Yet, few patients discuss NCT use with their MDs. MDs may not initiate or facilitate such discussions because they do not appreciate the prevalence of NCT use, or because they do not believe NCTs benefit patients. To test these hypotheses, and determine correlates of NCT use, we surveyed MDs caring for persons with HIV, a population thought to be heavy NCT users. Eligible MDs were those identified by participants in a Boston, MA based HIV cohort study as their primary care MD. Sixty-eight percent (88/130) of eligible MDs returned surveys. Frequency of communication about NCTs at initial and follow-up visits was assessed using a 5-point scale ranging from "at every visit" to "never." MDs were asked to estimate how many of their patients' use each of 6 specific NCTs (high-dose vitamins, acupuncture, herbal therapy, homeopathy, relaxation therapy, and massage), using a 5-point scale ranging from "almost all" to "none." Potential correlates of NCT discussions at initial visits included MD characteristics (age, gender, race, sexual orientation, subspecialty training, primary care training, interviewing training, HIV caseload, interest in HIV care), practice characteristics (HIV risk factor mix, visit time), and MD self-use of NCTs.

Respondents were 33% female, 47% worked in teaching hospitals, and 40% were subspecialists. Forty-two to 63% of MDs reported that "some," "most," or "almost all" of their HIV patients used each of the 6 NCTs. Sixty-three percent of MDs reported that NCTs "often" or "usually" help HIV patients, and 35% reported NCT self-use in the last year. For initial and follow-up visits, only 25% and 4% of MDs, respectively, reported discussing NCTs at "most" or "every" visit. In bivariate analyses, significant correlates of NCT communication included HIV caseload, interest in HIV care, and self use of NCTs (all $p < .05$). In a multivariable model, HIV caseload ($p = .04$) was the only significant correlate.

In summary, despite awareness of frequent NCT use by patients and believing that NCT use is often helpful to patients, MDs do not consistently discuss NCTs with patients at either initial or follow-up visits. HIV caseload was the only independent correlate of NCT discussions. MDs may not be aware of the cost of these unproved therapies, or that 3/4 of the cost of NCTs is out of pocket. Alternatively, given the complexity of HIV care, other issues may take priority. Efforts to educate physicians about the frequency of NCT use are not likely to increase the frequency with which NCTs are discussed.